

Tips for GP trainees working in urology

Urology is a relatively small speciality with a large number of patients, and a very useful placement for GP trainees. It is full of bite-sized procedures and manageable protocols so you can become relatively independent during a placement. You will be asked to see many patients whom others have been unable to catheterise. With a few tricks of the trade you will consistently be able to help these patients and they will be very grateful for it. Most of these tips are as useful in the primary care setting as they are in a job in urology.

1. There are very few actual urological emergencies and they are uncommon; testicular torsion, priapism, an infected obstructed kidney, and severe renal trauma are the only things that will legitimately wake a consultant overnight.
2. Urological procedures are generally uncomfortable. Be honest with the patient about this. A good warning about the level of discomfort doesn't normally put patients off and may conversely lead to praise when it is better than expected.
3. Local anaesthetic gel doesn't 'numb' anything it only takes the edge off at most. Leave it for a good 1 minute to work.
4. Offer a chaperone. Don't get complacent, even for examinations on patients of your own sex.
5. Patients can be very nervous. A lot of what we do is very embarrassing and uncomfortable. Don't mistake bravado, which is common, for a lack of nerves.
6. Patients generally like confidence. If you know what you are doing and go about a task with confidence you will normalise very foreign situations for the patient.
7. Cancer is always in the patient's mind even if it is not in yours. Appropriate reassurance causes great relief.
8. You are not a catheter service!
9. If someone has failed to catheterise a patient, go prepared with a bigger catheter.
10. For difficult or three-way catheters use

two lots of local anaesthetic gel.

11. Inflate the balloons with sterile water, not saline. Saline crystallises within the balloon, and then it can't be deflated.
12. Three-way catheters can have 30–40 mls in the balloon, make sure it is all aspirated before removing it.
13. If the catheter balloon doesn't deflate, cut the end of the port off.
14. Large prostates do not shrink the lumen of the urethra, they kink its path thereby changing the angle of the urethra leaving the prostate. Coudè tip catheters have a curved end that helps passage through the kinked prostatic urethra.
15. With prostatic obstruction, you will feel the catheter coiling in the bulbar urethra try:
 - a. two anaesthetic gels;
 - b. using a larger catheter; preferably long term as they are stiffer;
 - c. straighten the penis vertically;
 - d. insert until resistance is hit, before dropping the angle of the penis towards the bed and push further, and hopefully you'll be successful;
 - e. if not convinced, insert to the hilt, and wait (up to 30 seconds!). The catheter often seems to find its own way in;
 - f. a coudè tip catheter is the next step; and if you have still failed, stop and seek help. You may be damaging the urethra.
16. Try to do some flexible cystoscopies. This will give you a much better understanding of urethral anatomy, and helps with your catheterisation skills.
17. In an uncircumcised man always replace the foreskin.
18. Penile tip pain in catheterised patients is due to bladder spasm onto the catheter balloon, rather than penile irritation.
19. If you can't find a female urethra, it's probably on the anterior vaginal wall.
20. Obstruction from a urethral stricture feels like hitting a brick wall after going in only

T Renninson, MBChB, SHO, Frenchay Hospital, Bristol. **L Smith**, MRCS, SHO, University Hospital, Ayr. **M Burkes**, BSc, PhD, DRCOG, MRCP, Langley House Surgery, Chichester, West Sussex.

Address for correspondence

Thomas Renninson, Frenchay Hospital, Bristol, BS16 1LE, UK.

E-mail: tom.renninson@doctors.net.uk

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a short distance. Try using the smallest catheter but stop if you are still not succeeding. They may require urethral dilation, or a suprapubic catheter.

21. Suprapubic catheters are just normal catheters in a different anatomical location. They should be inserted (as an unplanned procedure) when: you have failed a urethral catheter; there is a palpable bladder, that is, the patient is in retention; or there are no concerns about bladder cancer. In these cases there is a risk of the tumour spreading down the catheter track, so always ask a senior.
22. Inserting a suprapubic catheter in someone with previous abdominal surgery has a risk of hitting bowel. If necessary, aspirating the bladder with a needle is a safer way to buy some time.
23. When changing a suprapubic catheter, clamp the old one for 30 minutes, it's reassuring to get urine out of the new catheter.
24. Urinary retention doesn't necessarily require hospital admission.
25. Retention with a residual volume of >600 mls warrants observing for 6–12 hours for diuresis, which may require fluid replacement, and test for renal function.
26. Retention with a residual volume of <600 mls can be discharged once catheterised, for a trial without catheter (TWOC) in the community when the cause, for example, constipation, prostatic hypertrophy, urinary tract infection (UTI), has been treated.
27. There is no point measuring a prostate-specific antigen (PSA) in the acute phase, it will be falsely high. Arrange for it to be taken after 6 weeks while awaiting outpatient appointments.
28. In high pressure chronic retention the catheter should always be left on free drainage. Never TWOC them before the patient has had definitive treatment for the cause of their retention.
29. Bilateral hydronephrosis and renal failure unresponsive to catheterisation is caused by ureteric obstruction and will require a nephrostomy(ies).
30. An infected obstructed kidney is an emergency, and requires a nephrostomy or retrograde stent ASAP.
31. Retrograde stents are near impossible in hydronephrotic prostate cancer patients; request antegrade stents.
32. 90% of bladder masses are cancer. Finasteride decreases the size and vascularity of the prostate, hence is great for pre-transurethral resection of the prostate (pre-TURP). However, be aware that it interferes with PSA results.
33. PSA can be low in prostate cancer and is associated with higher grade tumours.
34. To treat prolonged bleeding post TURP, inflate the three-way catheter balloon so it contains 40 mls of water, and hang over the end of the bed with a small amount of tension for a couple of hours. This helps tamponade the 'raw' area.
35. People rarely haemorrhage significantly from haematuria, so it rarely needs treatment to stop the bleeding.
36. Haematuria is a symptom, not a diagnosis. The underlying cause may be most appropriately treated admitting under another speciality.
37. Three way catheters are for haematuria or, explicitly, clot retention.
38. Catheter irrigation doesn't clear clots, it just stops new ones forming.
39. Bladder washouts break up clots, they are not gentle. You have to aspirate back hard to suck out the clots.
40. Microscopic haematuria after renal trauma doesn't require investigation, macroscopic however does.
41. If a renal stone is <6 mm or in the lower third of the ureter it will likely pass spontaneously.
42. Not all renal stones cause haematuria.
43. Tamsulosin causes ureteric smooth muscle relaxation which eases pain, and sometimes helps the passage of a stone. This is off label use, check local protocol.
44. You only need to admit renal colic if: pain is uncontrollable; there are signs of infection; renal function is deranged; or you are concerned about severe hydronephrosis.
45. Unless you already have radiolucent stones diagnosed, a CT of the kidneys, ureters, and bladder (KUB) is the imaging of choice, not a plain KUB X-ray.
46. Testicular torsion in someone >30 years is very rare. The diagnosis is more likely to be epididymitis/epididymo-orchitis, so get a urine dip and a sexual history.
47. In torsion there is only a 6-hour window to save the testicle.
48. A normal ultrasound doesn't rule out torsion, but can falsely reassure you.
49. A tortoid hydatid doesn't need surgery, although it can mimic a tortoid testicle. When in doubt, explore the scrotum.

Provenance

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